



## **Texas Department of Insurance**

### **Division of Workers' Compensation**

Medical Fee Dispute Resolution, MS-48

7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645

518-804-4000 telephone • 512-804-4811 fax • [www.tdi.texas.gov](http://www.tdi.texas.gov)

## **MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION**

### **GENERAL INFORMATION**

#### **Requestor Name and Address**

JOHN BOURLAND, MD  
PO BOX 121589  
ARLINGTON, TEXAS 76012

#### **Respondent Name**

NEW HAMPSHIRE INSURANCE CO

#### **Carrier's Austin Representative Box**

Box Number 19

#### **MFDR Tracking Number**

M4-10-1522-01

### **REQUESTOR'S POSITION SUMMARY**

**Requestor's Position Summary:** "Not paid per the DWC Fee Guides"

**Amount in Dispute:** \$300.00

### **RESPONDENT'S POSITION SUMMARY**

**Respondent's Position Summary:** "Corvel contends this was paid correctly based on documentation submitted with the original bill. The original bill did NOT include a report of findings as required by rule. The provider sent a fax cover sheet, HCFA billing form and a copy of the DWC-032 form (request for designated doctor exam) which indicates that MMI and IR were requested. Unfortunately, without a report detailing which method was used to determine IR, payment could not be allotted for this portion of the DD exam. A good faith payment for the MMI was allowed. The healthcare provided [sic] did not submit reconsideration. The provider did submit a 1 page HCFA bill and even that one page was not stamped "request for reconsideration" (even though we are aware that the bills DO NOT have to be stamped with this identifier). The bill was considered a duplicate and before an [sic] MDR is submitted. This did not happen. As such, we ask that the MDR staff reject this request for MDR until the provider has properly submitted their request for reconsideration for DOS 7/15/09."

**Response Submitted by:** New Hampshire Ins. Co, 300 S. State Street, Syracuse, NY 13202

### **SUMMARY OF FINDINGS**

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
July 15, 2009	99456-W5-26 and 99456-W5-TC	\$300.00	\$300.00



## ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Sections 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to additional reimbursement for the services involved in this dispute. The Division hereby ORDERS the respondent to remit to the requestor the amount of \$300.00 plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this Order.

### Authorized Signature



Signature

Gregory Fournerat  
Medical Fee Dispute Resolution Officer

November 08, 2011  
Date

### ***YOUR RIGHT TO REQUEST AN APPEAL***

Either party to this medical fee dispute has a right to request an appeal. A request for hearing must be in writing and it must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party.**

**Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.**

